

Medical Lib.
JUL 20 1921

The Public Health Journal

OFFICIAL ORGAN

Canadian Public Health Association

Vol. XII

TORONTO, JUNE, 1921

No. 6

SPECIAL ARTICLES

MEDICAL ORGANIZATION IN GREAT BRITAIN

DR. J. HOWARD HOLBROOK

THE SCHICK REACTION IN THE CONTROL OF DIPHTHERIA

BEVERLEY HANNAH, M.B.

REPORT OF COMMITTEE ON RURAL COMMUNITIES

F. C. MIDDLETON, M.B.

IS THERE A SHORTAGE OF STUDENT NURSES?

SURVEY BY THE CANADIAN RED CROSS SOCIETY

\$2.00 per annum.

154 BAY ST., TORONTO

20 cents per copy.

MIGHT HAVE SAVED \$18,500

This sum belonging to a lady was lost while being transferred from one bank to another in New York City.

The money was the proceeds of a life insurance policy.

It is a great pity the amount was not transferred by cheque, but the

beneficiary preferred the cash, and it was lost.

Had the Insurance been paid to her in monthly instalments in place of a lump sum, there would have been no possibility of disaster.

We issue policies payable by monthly instalments throughout life; 240 being absolutely guaranteed.

The Mutual Life of Canada

Waterloo, Ontario

LONDON and SCOTTISH ASSURANCE CORPORATION LIMITED

Established in Canada 1863
FOR ALL CLASSES OF LIFE ASSURANCE

Scottish Metropolitan Assurance Company Limited

For Insurances against FIRE, ACCIDENT and SICKNESS;
GUARANTEE BONDS, ELEVATOR, AUTOMOBILES,
PUBLIC and TEAMS and EMPLOYERS' LIABILITY

Head Offices for Canada
London and Scottish Building, MONTREAL
TOTAL ASSETS EXCEED \$30,000,000
Manager for Canada, ALEXR. BISSETT
BRANCHES AND AGENCIES THROUGHOUT THE DOMINION

The Public Health Journal

VOL. XII.

TORONTO, JUNE, 1921

No. 6

Medical Organization in Great Britain

CONSULTATIVE COUNCIL ON MEDICAL AND ALLIED SERVICES. INTERIM REPORT ON THE FUTURE PROVISION OF MEDICAL AND ALLIED SERVICES.

SUMMARY BY DR. J. HOWARD HOLBROOK.

MEASURES for dealing with health and disease become, with increasing knowledge, more complex, and, therefore, less within the power of the individual to provide, but rather require combined efforts. Such combined efforts to yield the best results must be located in the same institution. As complexity and cost of treatment increase, the number of people who can afford to pay for a full range of services diminishes. Moreover, enlightened public opinion is appreciating the fact that the home does not always offer the best hygienic conditions.

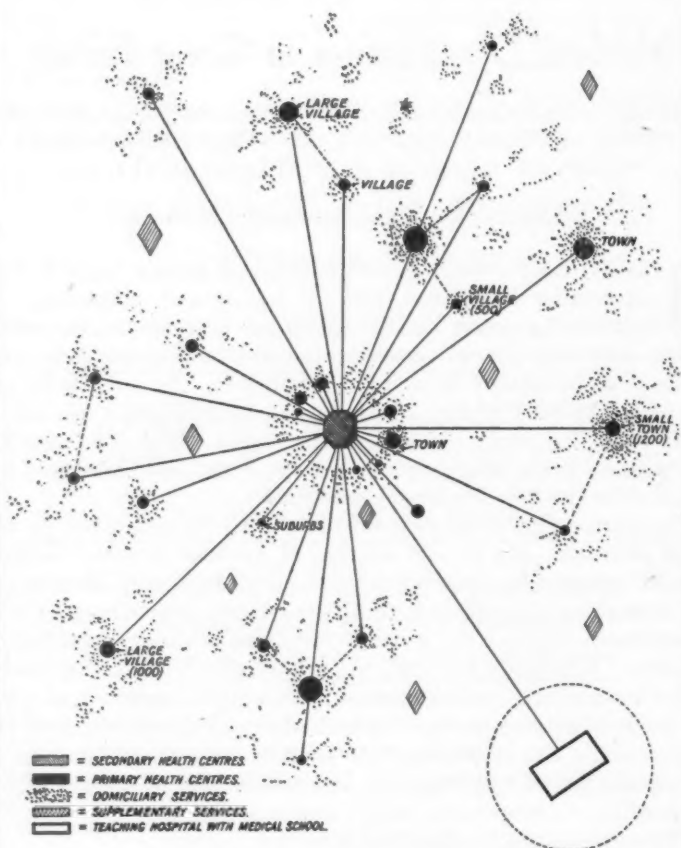
Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close co-ordination. They must likewise be both brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine. It appears that the present trend of the public health service towards the inclusion of certain special branches of curative work is tending to deprive both the medical student and the practitioner of the experience they need in these directions.

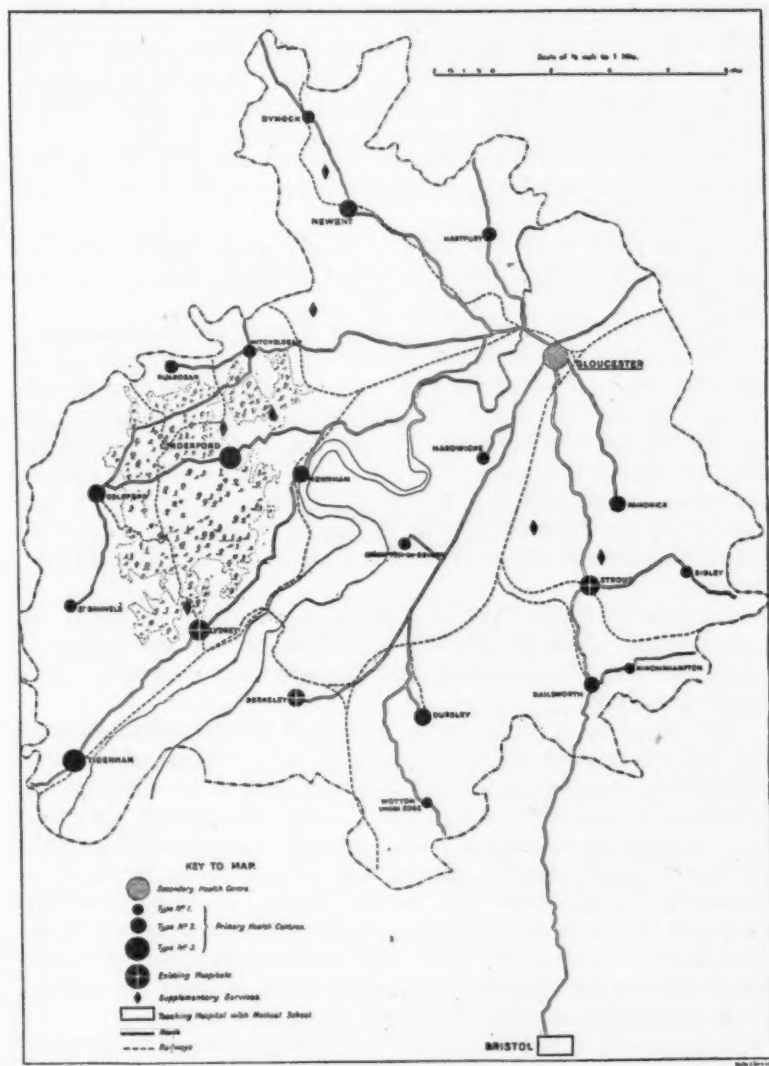
Any scheme of services must be available for all classes of the community.

The services may be classified into—

Those which are Domiciliary as distinct from those which are Institutional.

DIAGRAM OF AN AREA
SHOWING ALL SERVICES.





Those which are Individual as distinct from those which are Communal.

We begin with the home, and the services, preventive and curative, which revolve round it, viz., those of the doctor, dentist, pharmacist, nurse, midwife, and health visitor. These we style domiciliary services, and they constitute the periphery of the scheme, the remainder of which is mainly institutional in character.

A Health Centre is an institution wherein are brought together various medical services, preventive and curative, so as to form one organization.

Health Centres may be either Primary or Secondary, the former denoting a more simple, and the latter a more specialized service.

The domiciliary services of a given district would be based on a Primary Health Centre—an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district, in conjunction with an efficient nursing service and with the aid of visiting consultants and specialists. Primary Health Centres would vary in size and complexity according to local needs, and as to their situation in town or country, but they would for the most part be staffed by the general practitioners of their district, the patients retaining the services of their own doctors.

Secondary Health Centres must of necessity be situated in towns, where alone an efficient consultant service and adequate equipment could be expected, and the necessary means of communication exist.

The selection of these towns will need careful consideration, and full information will be required as to the extent of existing provision of hospital and allied facilities, and of its distribution in relation to population and means of public conveyance. In rural areas the natural currents of traffic and business and existing medical facilities will usually indicate the town or towns in which a Secondary Health Centre may best be placed. In this connection we would like to point out the importance of carrying out a "Hospital Survey" at an early date. The results of this survey would afford data for recognizing the areas in which the existing provision is inadequate, and the degree of the inadequacy.

The Secondary Health Centres would vary in size and elaboration according to circumstances.

Secondary Health Centres should in turn be brought into relation with a Teaching Hospital having a Medical School. This is desir-

able, first in the interest of the individual patient, that in difficult cases he may have the advantages of the highest skill available, and secondly in the interest of the medical men attached to the Primary and Secondary Centres, that they may have the opportunity to follow the later stages of an illness in which they have been concerned at the beginning, to make themselves acquainted with the treatment adopted, and to appreciate the needs of a patient after his return to his home.

Certain supplementary services would be a necessary part of the scheme. They would be in relation to both Primary and Secondary Health Centres, would often serve a wide area, and would require special staffs. They would comprise provision for patients suffering from such conditions as tuberculosis, mental diseases, epilepsy, certain infectious diseases, and for those in need of orthopaedic treatment.

Underlying our recommendations is the dominant purpose of providing the best services for the health of the people. Our recommendations are designed to secure—

- (1) Provision of buildings and equipment.
- (2) Services suitably correlated and available for all.
- (3) Opportunity for the best work and the furtherance of knowledge.
- (4) Co-ordination of preventive and curative medicine.
- (5) Freedom of action for doctor and patient.

PRIMARY HEALTH CENTRES.

Accommodation.—There would be wards of varying sizes, and for varying purposes, including provision for midwifery. The increasing employment of open-air treatment of illness would be provided for. Clinics would be equipped where doctors could see their patients and consult with each other.

Further accommodation might include the following:

- Operating room, with the necessary equipment.
- Radiography rooms.
- Laboratory for simple investigations.
- Dispensary.
- Baths, including simple hydro-therapy.
- Equipment needed for Massage, Electricity, Physical Culture.
- A Public Mortuary.

A Common Room which would serve as a meeting-place for the general practitioners of the district, and to store Clinical Records on an agreed and standardized basis.

The Personnel.—The general practitioner would attend at the Primary Centre such of his patients as required hospital treatment, irrespective of their status, though under varying conditions of service. Consultants and specialists from the staff of the Secondary Health Centre, to which the Primary Centre was attached, would attend under the conditions of the service at fixed intervals, and, under circumstances of emergency, on special summons. These or other consultants could attend patients other than those provided for at the Centre, if the patient paid for their services. The Primary Centre would provide the patient (on the terms described in paragraphs 72 and 73 below) with food, nursing, and all the equipment of efficient treatment, but not with medical attendance, which would be paid for either by the patient, or through some method of insurance, or by the health authority.

Efficiency of Service.—No small part of the advantage likely to follow from such institutional provision would be the raising of the standard of professional efficiency. Medical knowledge has far outstripped the means for its application. Within the hospital the student studies the problems of disease under favorable circumstances; he has near at hand, not only the equipment of the war, but the laboratories of radiography, pathology, and chemistry; he can marshal his observations, and follow up results. Under existing conditions he leaves hospital for practice, and there is a sudden drop to the limited opportunities attached to the crowded surgery and the patient's home, and the more medical knowledge advances the bigger the drop becomes. In the Health Centre there would be the equipment and the encouragement to do good work, and opportunities for observation and investigation and self-improvement. Disease, too, would be detected in its earlier, and, therefore, more curable stages. Judged alone by the effect on medical men and medical knowledge, it would be impossible to exaggerate the benefits that would accrue to the community by the establishment of these Health Centres.

Whole-time and Part-time Services.—The alternative of a whole-time salaried service for all doctors has received our careful consideration, and we are of opinion that by its adoption the public would be serious losers.

No doubt laboratory workers and medical administrators who do not come in personal contact with the sick man would, with advantage, be paid entirely by salary.

The clinical worker, however, requires knowledge not only of the disease, but of the patient; his work is more individual, and if

he is to win the confidence so vital to the treatment of illness, there must be a basis not only of sound knowledge but of personal harmony. The voluntary character of the association between doctor and patient stimulates in the former the desire to excel both in skill and helpfulness. It is a true instinct which demands "free choice of doctor," and there should be every effort, wherever possible, to make this choice a reality. In no calling is there such a gap between perfunctory routine and the best endeavour, and the latter, in our opinion, would not be obtained under a whole-time State salaried service which would tend, by its machinery, to discourage initiative, to diminish the sense of responsibility, and to encourage mediocrity.

SECONDARY HEALTH CENTRES.

The services of the Secondary Health Centres would be mainly of a consultative type. The Centres would receive cases referred to them by the Primary Centres, either on account of difficulties of diagnosis or because in their diagnosis or treatment a highly specialized equipment was needful. On the other hand, Primary Centres would ease the work of the Secondary Centres by treating less complex cases which are now sent to the larger hospitals, and by receiving patients from the Secondary Centres when the acute stage of their illness had passed. Although in some places, e.g., in smaller towns, it would be necessary to have primary services also performed in Secondary Health Centres, these should not be allowed to interfere with the consulting functions of the Secondary Centre.

Most of the Communal Services of the Secondary Health Centres would resemble in function the Communal Services of the Primary Centres, but should be models of equipment and organization, for they would have very important educational functions and would be centres of post-graduate study for doctors and training for nurses and others.

Method of Remuneration of Consultants.—These consultants would be part-time officers, and be paid on a time basis with extra fees for special visits. This would leave them time for their private consulting practice.

Consultants (Non-Clinical).—The pathologists, radiologists, and the officers connected with the Communal and Preventive services of the Secondary Health Centres would similarly visit in a consulting capacity the Primary Health Centres within the spheres

of their Secondary Centre. Certain of these would be whole-time officers.

The test of eligibility to serve as a consultant or specialist would be evidence of special training and experience of the requisite kind. This evidence would be afforded by consideration of such points as—

- (1) Special academic or post-graduate study.
- (2) Tenure of hospital and other appointments affording special opportunities for acquiring experience; and
- (3) Local professional recognition of competence in a consultative or expert capacity.

While all these points would afford indications to which due regard should be paid, no one of them would be considered to be in itself indispensable.

We contemplate that general practitioners should be eligible for these posts, and we should regard their representation in the consultant service and on the staffs of the Secondary Health Centres as an advantage.

Payment for Treatment at Health Centres.—Certain members of the Council are of the opinion that curative services at Health Centres should be provided by the health authority free of charge to the individual patient. The majority of the members, however, consider that this course would impose a heavy burden on public funds. Preventive services must of necessity be publicly provided; their relation to the individual is less obvious and personal. On the other hand, illness is a direct personal concern, and experience has shown that the patient, when able, is willing to contribute in some form or other to the cost of its treatment. It could, as a rule, only be a contribution to the cost, for it has already been pointed out that efficient treatment will often be beyond the means of most citizens to provide in its entirety.

We recommend that standard charges should be made in the public wards and for other curative services, though it is possible this standard charge might vary in different parts of the country.

We contemplate that such charges would more often be met by some method of insurance, though private patients recommended by their doctors would have the right to avail themselves of these services by direct payment.

SUPPLEMENTARY SERVICES.

With both Primary and Secondary Health Centres there would be correlated certain institutional services from time to time neces-

sary to each. Such services, termed "supplementary," may be exemplified by the following:

Sanatoria for tuberculosis.

Recuperative centres (convalescent centres).

Hospitals for curable or incurable mental disease.

Institutions for the feeble-minded.

Epileptic colonies.

Orthopaedic centres.

Hospitals for certain infectious diseases.

In those parts of the country where it is geographically possible, it is desirable that every Secondary Health Centre should be brought into relationship with a Teaching Hospital.

The Teaching Hospital would receive cases of unusual difficulty, and those requiring specialized knowledge or equipment, and in so far as is necessary, patients suitable for either primary or secondary hospitals should be freely admitted to Teaching Hospitals.

The Teaching Hospital could initiate and guide collective investigations in which the health centres and doctors connected with them could play an important part.

The Schick Reaction in the Control of Diphtheria

BEVERLEY HANNAH, M.B. (Tor.); M.R.C.S. Eng.; L.R.C.P. London.
Hospital for Sick Children, Toronto

THE history of Diphtheria prevailed through many centuries, but it was not until about 1855 that the medical profession began to recognize it as a definite disease, and place Diphtheria in the category of Communicable Diseases. Twenty-eight years later, in 1883, Klebs brought forward his work on the bacteriology of Diphtheria. In 1885 he and Loeffler combined their work, giving to medical science a definite organism, the Klebs-Loeffler Bacillus with its bacteriology and morphology, as the cause of diphtheria. Another period elapsed until 1894, when Von Behring introduced antitoxin for the treatment of this disease. Each year has seen the Health Departments putting forth strenuous efforts for the control of diphtheria and other communicable diseases. There has resulted a steady decrease in the prevalence and mortality of this disease. However, with all our modern preventative and curative methods, these two factors are decidedly too great.

Another advance in preventive medicine came in 1913, when Schick introduced his work on the immunity test in diphtheria. He used as a basis for his work the following fact: A person is immune to the diphtheria toxins when, immediately after these enter the body-tissues, they become neutralized and therefore without any effect. The diphtheria toxin was standardized as to its effect upon a 250 gram guinea-pig, and the M.L.D. (minimal lethal dose) determined. It was then found that 1/50 of the M.L.D. was sufficient for carrying out this immunity test in man.

A fresh solution of the diphtheria toxin is prepared and put up in sealed capillary tubes by the various laboratories. The strength of each tube is standardized so that when mixed with 20 c.c. of physiological salt solution 0.2 c.c. represents 1/50 M.L.D. of toxin for a 250 gram guinea-pig. The contents of each tube will retain its quality for a considerable period of time, but the mixed solution is good only for 24 hours:

The technique employed in performing this test is as follows: A 1 c.c. Record syringe finely graduated, with a number 26 gauge $\frac{3}{4}$ " short bevel point needle are requisite for injecting these solutions.

The test is entirely intracutaneous. The mixed toxin is injected on

the flexor surface of the forearm. When properly performed, there occurs at the point of insertion a whitish blister like elevation with slight depressions on its surface, corresponding with the hair follicles. The reading of the test should be carried out at the end of 24, 48, 72 and 96 hours.

The reaction that appears at the site of injection may be either positive, negative, pseudo or combined positive and pseudo.

The positive reaction represents the action of an irritant toxin upon tissue cells that are not protected by antitoxin. It indicates, therefore, an absence of immunity to diphtheria. A trace of redness appears slowly at the sight of injection in from 12 to 24 hours, and usually a distinct reaction in the course of 24 to 48 hours. The reaction reaches its height on the 3rd or 4th day and gradually disappears, leaving a definitely circumscribed scaling area of brownish pigmentation, which persists for 6 weeks. At its height the positive reaction consists of a circumscribed area of redness and slight infiltration, which measures from 1 to 2 cm. in diameter. The degree of redness and infiltration varies to a great extent with the relative susceptibility of the individual.

In the negative reaction the skin at the site of the injection remains normal. The negative reaction definitely indicates an immunity to diphtheria if the test toxin is of full strength, has been freshly diluted, and the injection has been made into the proper layer of the skin.

The pseudo reaction represents a local anaphylactic response of the cells to the protein of the autolysed diphtheria bacilli, which is present in the toxin broth used for the test. Like other anaphylactic skin phenomena, the reaction is of an urticarial nature, appears early, within 6 to 18 hours, reaches its height in 36 to 48 hours and disappears on the 3rd or 4th day, leaving a poorly defined small area of brownish pigmentation and generally scaling. At its height the pseudo-reaction shows varying degrees of infiltration, and appears as a small centre area of dusky redness with a secondary areola, which gradually shades off into the surrounding skin. The reaction may also have a rather uniform red appearance and be 2 or 3 times the size of a true reaction. Such pseudo-reactions have been comparatively infrequent with our work in children.

A control test as advocated by Groer and Kassowitz may also be used. This control injection contains the same amount of toxin as the Schick test, together with several hundred times the necessary antitoxin to neutralize the poison. Thus far in our work we have not found occasion to utilize this control test because there has not been any difficulty in reading any of the reactions.

The work of this paper on the Schick test has been conducted in the wards of the Hospital for Sick Children. It has extended over a period

of 18 months. During that time over 2,000 children have had this test performed upon them. Our statistics correspond very closely to those of Schick, Park, Zinger and various other workers along this line. It includes children of all ages up to 15 years. To these have been added the results in people after that period of life as found by other observers.

	Percentage Positive	
Under 3 months.....	11.5	15 (Schick)
3 to 6 months.....	27.5	30 "
6 months to 1 year.....	53.0	60 "
1 to 2 years.....	61.0	70 "
2 to 3 years.....	64.4	60 "
3 to 5 years.....	41.3	40 "
5 to 10 years.....	30.0	30 "
10 to 15 years.....	23.5	" "
10 to 20 years.....	..	20 "
Over 20 years.....	..	15 "

It is interesting to note from the above figures the increase in susceptibility of children up to 3 years of age. Following these years, there comes a gradual increase in immunity up to 15 years of age, when it is found that about 10% to 15% of adults are susceptible to diphtheria. Reviewing these statistics on the prevalence and mortality of diphtheria, we are struck by the fact that the percentage-rate is greatest between the ages of 1 and 5 years. This intimate relationship between the age of greatest susceptibility and highest percentage-rate of prevalence and mortality in diphtheria, is sufficient to justify the value of Schick's work on the immunity test in Diphtheria.

The intensity of reactions is greatly influenced by the preparation of the toxin used. It is highly essential that the toxin be properly standardized and distributed by a reliable laboratory. Changes in the immunity of individuals vary with their general health, as in other diseases. This important fact will require consideration in our future work with the Schick test. Park states that this is particularly noticeable in scarlet fever patients, who show a decided susceptibility to the Klebs-Loeffler bacillus and its toxin. The season of the year has been found to offer very slight influence upon the test.

The Schick test is practically free from any complications or ill effects. The question of local necrosis after the reaction occurred in six of our series. It was noted in the form of a bleb 3 to 4 cm. in diameter. These all healed readily without any local treatment. Both Schick and Lucas state that they have occasionally encountered a similar condition, and that all cultures from contents of these blebs were sterile. This reaction was probably caused when stronger solution of toxin or too large quantities were used.

The Schick reaction must necessarily be a simple procedure and of practical application if we can hope to utilize it to advantage in the control of diphtheria. The various laboratories have done much to simplify the technique. They have provided standardized solutions with printed instructions which are readily obtainable. Its greatest value is to be found in the schools, hospitals, and various children's institutions of which there are many. It has been interesting to note the gradual decline of diphtheria cases in the wards of the Hospital for Sick Children since the introduction of the Schick test. It enables us to separate our susceptible and immune individuals, and provide the former with the required immunity. This is applicable not only to patients but all inmates of these institutions. Diphtheria prevails during the school period. Accordingly, the schools should be one of the chief places to introduce the Schick reaction in the control of this disease.

It is highly probable that this test will become part of the routine of public health work. We have at our disposal a simple and practical procedure which should lend itself readily in assisting to prevent the spread of this dread disease which has been so prevalent in the past. Although our work is only in its early stages, we are able to recognize certain facts;

1. The Schick test is a simple and reliable reaction; a negative result indicating a definite immunity to diphtheria and a positive one, that the individual is susceptible to the Klebs-Loeffler bacillus and its toxins.

2. The solution of toxin used must be standardized by a reliable laboratory.

3. Its chief value is applicable to institutions, schools, hospitals and various children's organizations.

4. The test is free from danger.

5. It is of economic value, in preventing the promiscuous administration of antitoxin, both public and private.

6. The Schick reaction offers us a ready means to aiding in the future control of Diphtheria.

Paper read before Section of State Medicine, Academy of Medicine, Toronto, February 24th, 1921.

Report of Committee on Rural Communities, Nursing and Social

BY F. C. MIDDLETON, M.B.

Presented at National Health Congress, Toronto
May 17th, 1921

Committee: MISS GUNN, Lady Superintendent, Toronto General Hospital; MRS. HANNINGTON, Victorian Order of Nurses; MISS MARY POWER, Provincial Board of Health, Toronto; DR. HATTIE, Medical Officer of Health of Nova Scotia; DR. W. J. BELL, Provincial Board of Health of Toronto; DR. F. C. MIDDLETON, Bureau of Public Health, Regina (*Chairman*).

AT the Convention held in Vancouver last year, I had the honour to be chosen Chairman of the Committee on Rural Communities, Nursing and Social, and was given the privilege of naming the other members of this committee, with the result that I was fortunate in securing the following to act: Miss Gunn, Lady Superintendent of Toronto General Hospital. Mrs. Hannington, of the Victorian Order of Nurses; Miss Power, of the Provincial Board of Health of Ontario; Dr. Hattie, Medical Officer of Health of Nova Scotia, and Dr. W. J. Bell of the Provincial Board of Health of Ontario.

At the Vancouver meeting we had arranged for a paper on "The Peace Time Policy of the Red Cross", to be given by Professor Fitzgerald, but it was considered that this paper was one of such general interest that it was decided to have it read at an evening session which was thrown open to the general public. The proposals decided upon at the Geneva Conference were clearly outlined by Professor Fitzgerald, showing that the policy of the Red Cross was to act in an auxilliary capacity to the existing Health organizations, and that the Health organizations should continue to be, as formerly, the clearing houses for all matters pertaining to Public Health.

Fitting in very nicely with the above paper, was a paper prepared by Dr. Hattie, on the co-ordination of the different voluntary organizations doing public health work, in which a desire was expressed that all voluntary organizations doing public health work should be guided in such a way that their work would be undertaken where most required and that overlapping should be guarded against.

In gathering together a brief report from the various provinces as to their activities for the past year along the lines of rural nursing, it

would appear that each province handles this phase of its public health work in a manner peculiar to itself and absence of uniformity is the prevailing feature.

The prairie provinces apparently look upon the rural nursing problems with more favour than the others, for the reason no doubt that their population is largely rural.

In reviewing the work being undertaken by the several provinces, it is indeed encouraging to find that a great deal of attention is being given to the rural communities in endeavouring to supply these outlying districts with better nursing facilities.

In British Columbia during the past year, twelve nurses have been established, the Red Cross having co-operated with the Provincial Board of Health by giving the necessary financial assistance.

The municipality of Saanish adjoining Victoria, is spending \$25,000 for the erection and equipping of a building to be used as a Health Centre for this municipality, where their nurses will make their headquarters.

The Provincial scheme is to guarantee the salary of a nurse in a district for six months of a year, when it is hoped the work will become self-supporting.

Boards of School trustees may now employ nurses and dentists on the same basis as they employ teachers, the Government paying the rural schools \$580 a year towards salary.

A Faculty of Nursing has been established in the University of British Columbia, which includes a public health nursing course and 22 nurses completed this course in March. The Victorian Order of Nurses have been utilized for the practical training in connection with the University Course.

The Women's Institute and other such organizations are used as a nucleus in promoting child welfare work.

In Alberta this year, a special course was put on by the University of Alberta at the request of the Government, and fourteen nurses received training in Public Health Work. Public Health Nurses, Child Welfare Nurses, District Nurses, Tuberculosis Nurses and Nurses in Venereal Disease Clinics, to the number of twenty, are employed by the Provincial Board and it is expected that each branch of this work will be largely extended this year.

A system of municipal Hospitals in Alberta is relieving the rural districts to a satisfactory degree.

In the Province of Saskatchewan we have endeavoured to supply our rural districts with the combined service of hospital accommodation and nursing care, by the establishing of Union Municipal Hospitals, and we have been successful to the extent that we now have one hospital bed for every 400 of our population, and our people are being educated

to use these hospitals for their maternity work, so that at present one child out of every eight born in Saskatchewan is born in a hospital. We have found that where the facilities for caring for the sick are provided within easy reach of the people it requires very little education to get them to take advantage of these facilities, whereas, the education is of greatly discounted value, unless provision is made whereby the education may be put into practical use. These two conditions cannot be separated.

Nine rural municipalities have each engaged a municipal nurse and five others have engaged a municipal doctor. Under the Supervision of the Commissioner of Public Health, two nurses are engaged in visiting the villages, giving short courses in home nursing for the benefit of the women in the community, and these courses have also been given to the Soldier Settlers' Wives, during their conventions in the different parts of the province. Where requested Baby Clinics are also conducted at the conclusion of these courses and a system of follow up work is carried out where the examination indicates the need for this. During the summer these conferences are conducted in connection with the fairs. Public Health literature and the booklet, "The Baby" are distributed at these courses.

A nursing housekeeper course has been established to provide an assistant nursing body who will assist in the rural homes in case of illness.

A specially qualified nurse visits homes where tuberculosis exists to see that those in charge carry out the instructions of the attending physician with a view to preventing the spread of the disease.

A male and female social service nurse are engaged in connection with the carrying out of the provisions of our venereal disease act. A nurse specially trained in Trachoma work is engaged in seeing that regular treatment is given those requiring same. This nurse lives in a rural district where this disease is fairly prevalent.

A maternity grant of \$25.00 is given to prospective mothers in rural district who for financial or other reasons might not be able to secure the services of a nurse or doctor at time of her confinement.

Under the Department of Education a staff of 12 nurses, doing school hygiene work last year visited 1,121 schools mostly rural, and inspected 33,831 pupils.

The Red Cross has assisted the outlying districts in the following manner: by giving financial aid to equip some of the needy municipal hospitals: by assisting financially some of the poorer municipalities, where a municipal nurse is engaged. They have built and equipped a Red Cross outpost in the far north and have a nurse established there.

They are undertaking to equip a travelling dental clinic for the more remote districts this summer.

Manitoba has probably the largest public health nursing service of any of our provinces and all under the supervision of the Provincial Board of Health. At the end of 1920 there were 43 nurses on this staff, who performed the duties of school nurse and community nurse. Some 28,000 inspections and 2,165 class room inspections were made, 3,612 school room talks were given, 17,813 home visits (a very important feature) were made; 581 demonstrations were given and 387 Little Mother League classes for older girls were held. 244 Public lectures on health topics were also given.

Special attention is being given to the Little Mothers' Leagues. Seven Child Welfare stations have been opened and 125 child welfare clinics held. Follow up visits are paid where necessary to the babies examined at the clinics.

The Red Cross have furnished three nurses to be stationed in un-organized territory, which nurses are controlled and supervised by the Provincial Board of Health. They undertake to do actual nursing and when not so engaged carry on educational work. Their territory extends for a radius of from 15 to 20 miles from where the nurse is stationed.

Ontario.

Following the appropriation of \$40,000 by the Provincial Legislature in 1920 the Provincial Board of Health was enabled to establish a Division of Maternal and Child Welfare. In June of last year, eight nurses were appointed, who, with the exception of one, had had previous Public Health experience. One month later the Ontario Division of the Red Cross supplied eight additional nurses, to be under the supervision of the Provincial Board of Health.

An intensive course in Child Hygiene was given for a period of three months, following which two of the nurses were assigned to each of the eight Health Districts of the Province.

The aim of the Department is to give a complete demonstration of generalized Public Health Nursing in a community desiring the same, and then to urge that municipality to appoint and support their own nurse.

The following is a summary of the work accomplished and of that at present under way:

23 Demonstrations and 32 surveys of existing conditions in various districts have been completed.

8 permanent nurses have been appointed as a direct result of the Public Health Demonstrations, while 7 additional applications for public health nurses have been received.

Further demonstrations are being carried on in 8 communities at the present time.

Quebec is preparing a campaign against infant mortality and tuberculosis more particularly, and funds for this work are being obtained largely by the Provincial Government taxing all amusements.

New Brunswick is just getting started with its scheme of rural nursing and already a training school for public health nurses has been established with the understanding that as these nurses graduate they will go to districts decided upon by the Department of Public Health.

Victorian Order Nurses have been placed in a number of semi-rural districts.

Financial assistance is expected from the Red Cross for the first year the Public Health nurses are sent out and after that the municipalities will be required to supply the funds for this work.

In *Nova Scotia*, during the summer of 1920, the Red Cross equipped three health caravans carrying expert medical, dental and nursing service to the most isolated districts of the province.

The Department of Public Health is endeavouring to establish at least one health clinic in each county, and the Red Cross have contributed \$25,000 to maintain a trained public health nurse in each county for a year. Already nine counties have furnished clinic rooms and nine nurses are on duty. Three more will be added this month. These nurses have made partial examination of over 15,000 pupils since October 1st.

The county public health nurse and a local physician are in attendance at each clinic every Friday.

In summarizing what is being undertaken by the several provinces, along the lines of supplying nursing facilities to the rural districts, the outstanding feature appears to be the attention that is being given to the inspection of school children by the nurses, and this brings us at once to a question suggested by one of the members of the Committee, viz., to what extent should nurses carry on this examination?

The report would also naturally lead us to ask what is being done for the child of pre school age. This is an age which is apparently being neglected. Finally, is sufficient attention being given to the prenatal period in our nursing schemes?

Had space on the programme permitted, two of our committee had suggested a paper on school nursing, taking up the advantages of control by Department of Education and Department of Health, but unless discussion on this is fully entered into, your new committee might well keep this in view for a later meeting.

Is There a Shortage of Student Nurses?

A Survey made by the Canadian Red Cross Society

THE survey upon which this study is based was made by the Canadian Red Cross Society in February, 1921, at the request of the Canadian National Association of Trained Nurses and the Canadian Association of Nursing Education to determine the extent, degree, causes and possible remedies for the apparent shortage of pupil nurses in the training schools of Canada. A questionnaire was prepared with the assistance of Miss Gunn and Miss Flaws and sent with an explanatory letter to the Superintendents of 219 Training Schools throughout Canada.

More than half of the questionnaires were answered¹ representing, with the exception of British Columbia and Quebec, a majority of hospitals in each Province². The replies received were classified evenly among small, medium and large-sized hospitals. For these reasons the facts elicited may be considered to represent with fairness and reasonable accuracy the situation at that time.

A shortage of student nurses was reported by 39 out of 98 training schools. Though a shortage of 40% cannot be considered extreme yet many of the answers indicate that a shortage did exist until the completion of military demobilization and altered economic conditions decreased the demand for young women in occupations undertaken by them during the war. This answer may be considered a fair representation of conditions in January, 1921, for as was pointed out in the introductory remarks, these schools are distributed evenly as to province and size of hospital and the figures include nearly one-half of the schools in Canada.

To what causes was this shortage attributed? The cause most frequently assigned was "the attractiveness of other occupations." This single cause was paramount and scored more points than did almost all other causes added together.³ The superintendents of the schools affected had tried to remedy the shortage by advertising and publicity, by better quarters and by increasing the cash allowances.⁴ The result in most cases had not been encouraging.

The intensity of the shortage according to Provinces is shown by the following table:

Manitoba.....	3 out of 5 replies (60%)
British Columbia.....	7 out of 13 replies (54%)

Ontario.....21 out of 53 replies (40%)

Saskatchewan..... 3 out of 9 replies (33%)

Minor shortages were reported by the other provinces.⁵

In addition to the fundamental question of the existence of a shortage some interesting facts were revealed regarding the profession of nursing.

Size of Hospital.—The average number of beds in hospitals with training schools was 143. These hospitals divided into three groups of almost equal size:²

1. Small hospitals with not more than 50 beds.
2. Medium sized hospitals with from 51 to 100 beds.
3. Large hospitals with over 100 beds.

Activity of hospitals. The degree of activity of these hospitals may be judged by the fact that an average of 79% of the beds were reported as being in daily use.⁶

Teaching Staff.—The number of graduate nurses employed gave a rough indication of the staff available for nursing patients and instructing students. There was one graduate nurse for every 16 beds and for every 5 students.⁷

Preparatory Occupation.—Many girls on leaving school wish to study nursing but are necessarily prevented by reason of their extreme youth. To answer the oft-repeated inquiry of these young girls as to the best means of filling in time between High School and Training School, Superintendents were asked to suggest a remunerative occupation or a course of study that a girl might take up on leaving school until she was old enough to commence training, and which would assist her subsequent career as a nurse. The collective wisdom of the Superintendents indicated courses in Household Science or Dietetics as by far the most useful bridge between High School and Training School.⁸

Length of Course.—The three year course was almost the rule; ninety-three having this length of training as compared with four schools giving a course of two years.

Supply of Students.—This is estimated by comparing the applications and enrollments for 1915 with those for 1920. In interpreting these figures it should be remembered that 1915 was a war year, in which many young women sought admission or were actually enrolled in the hope of becoming Army Nursing Sisters.

In 1915 there were 7,740 applications made to 46 Hospital Training schools. In 1920 the same hospitals had only 4,760 applications. This tremendous numerical decrease is more apparent than real and was due to a flood of applications to the larger hospitals during the war year, for the hospitals showing an increase in applications are almost as numerous as those reporting a decrease.⁹

The number of students enrolled in 70 hospitals in 1915 was 1,707.

The same hospitals enrolled 2,365 students in 1920. Comparing the enrollments for 1915 with those for 1920, an increase was reported by 52 and a decrease by 12, six remaining unchanged.

Without a knowledge of the undoubted increase in bed capacity during this period of 5 years reasonable deductions from the foregoing figures cannot be made.

Number of Student Nurses.—The average number of student nurses in hospital training schools was 40.3 or one student nurse to every 3.5 beds. On this basis it is estimated that there are nearly 9,000 young women in the nurse training schools of Canada.

Age Limits.—The average minimum age limit for entrance to the schools is nineteen years. The most frequent is eighteen years, though three schools accept girls of seventeen, and one school will not take a girl who is younger than 23. By far the most frequent upper age limit is 35 years, though three schools will not accept applicants older than 25 and an equal number of schools have no definite senior age limit ¹⁰

Educational Qualifications.—It was difficult to determine with accuracy the educational standard demanded of an applicant because some schools set up standards that are more honoured in the breach than in observance, and many add to their nominal standard that convenient but elastic phrase "or its equivalent." Three schools frankly admitted the absence of any definite standard whatever. "One year at High School or its equivalent" was stated to be the standard in 51 schools, while 19 schools demanded two years of High School training and a slightly greater number were satisfied with High School Entrance. After all, the laxity in this matter is of relatively small importance, when one considers the variety in examination standards of apparent equality, the lack of correspondence between education and ability, and the greater importance of the Superintendent's personal estimation of the potentialities of an applicant. On the other hand standards are, or should be, definite, and it is superfluous to point out to you that the steadily increasing complexity of the technicalities of modern scientific nursing make it impossible to instruct adequately a pupil of inferior general education. That this fact is generally appreciated by Superintendents is shown by a glance at the figures giving causes for which unsuccessful applicants were rejected.¹¹ By far the most frequent cause of rejection is lack of educational qualification, and the total for this cause almost equals the combined totals for all other causes. "Do you consider the educational standard too high?" was a question answered in the negative by over three-quarters of the Superintendents replying.

These facts show the good results of the firm stand taken by your Association in pressing steadily for a higher educational standard for student nurses.

Cash Allowances.—Nearly 93% of the schools give a cash allowance to student nurses in all years. This allowance varies from a minimum of \$2 a month in the first year to a maximum of \$30 a month in the third year, the average allowances being as follows:

First year.....	\$7.26
Second year.....	8.79
Third year.....	10.32

Uniforms and Texts.—Free uniforms were supplied in one-half of the schools, while a few others gave the material from which the uniforms were to be made. Free text books were supplied in 22% of the schools.¹²

Hours of Duty.—The ten hour day is by far the most usual, occurring in 59 instances, as compared with fourteen of 9 hours and sixteen of 8 hours. An eleven hour day was admitted by five schools.

Vacation.—Vacations of a fortnight and three weeks divide the honours nearly evenly. A month's holiday is allowed in three schools.¹³

Supply of Graduates.—1,138 nurses were graduated by 72 schools in 1915, and the same schools in 1920 graduated 1,519. It is questionable if this increased annual output of nearly 400 graduate nurses is sufficient to offset the demand caused by the increased number and size of hospitals, in addition to the ever-widening range of nursing activities in the fields of industrial and public health nursing.

Excluding the unusual conditions occasioned by the pandemic of influenza, a shortage of graduate nurses for ordinary demands of the community was reported in almost 50% of cases.¹⁴ The lack of graduates was chiefly for private nursing in homes, and was explained by the unsatisfactory conditions in the homes and the preference for public health and institutional work.

Conclusion.—This survey was made with your co-operation as a result of the request that the Canadian Red Cross Society should assist the National Nursing Associations in a campaign to recruit student nurses. While the results do not indicate a degree of shortage sufficient to justify action of a national character, yet in British Columbia, Manitoba and Ontario the needs of the situation are sufficient to justify Provincial action, and the Provincial Divisions of the Red Cross have been advised of the results of the survey in order that they may be in a position to co-operate with their respective Provincial Graduate Nurses' Associations.

REFERENCES

Province	Questionnaires	Replies
	sent	Received
Alberta.....	21	12
British Columbia.....	38	13
Manitoba.....	9	5

<i>Province</i>	<i>Questionnaires sent</i>	<i>Replies Received</i>
New Brunswick.....	9	7
Nova Scotia.....	14	9
Ontario.....	77	53
P.E. Island.....	4	3
Quebec.....	30	14
Saskatchewan.....	17	9
	219	125

^aSizes of Hospitals:

Small Hospitals (50 beds or less).....	28
Medium Hospitals (51 to 100 beds).....	29
Large Hospitals (more than 100 beds).....	31

^bCauses for the Shortage of Student Nurses:

Other occupations more attractive.....	21 instances
Lack of educational qualifications.....	8 instances
Difficulties of small hospitals.....	5 instances
Poor quarters.....	4 instances
Hardships of training.....	2 instances
Inadequate salary.....	2 instances
Emigration to U.S.A.....	2 instances

^cSuggested Remedies for the Shortage:

Shorter hours.....	10 cases
Better quarters.....	9 cases
Advertising.....	7 cases
Increased salary.....	6 cases
Longer High School training.....	3 cases
Reduced age for entrance.....	} 1 case each
Higher educational standard.....	
Lower educational standard.....	
Scholarships.....	
Less "menial" work.....	
Longer vacation.....	}
Shorter course.....	

Remedies Actually Tried:

Advertising and speeches.....	15 cases
Improved quarters.....	6 cases
Increased salary.....	4 cases
Shorter hours.....	2 cases
More maidservants.....	2 cases

^dMinor Shortages Reported:

Alberta.....	Shortages in 2 out of 12 replies
Quebec.....	" " 2 out of 14 replies
Nova Scotia.....	" " 1 out of 9 replies
New Brunswick.....	" " 0 out of 7 replies
Prince Edward Island.....	" " 0 out of 3 replies

⁶ *Activities of Hospitals:*

Replies received.....	92
Average number of beds occupied daily.....	112.41
Percentage of beds occupied daily.....	78.8

⁷ *Graduate Nurses on the Staff:*

Replies received.....	95
Total number of graduate nurses, including superintendent.....	828
Average number of graduates to each hospital.....	8.72
Average number of beds to each graduate.....	16.36
Average number of student nurses to each graduate.....	4.67

⁸ *Suggested Preparatory Training:*

Course in Household Science or Dietetics.....	43
Office work.....	17
Business Course.....	16
School Teaching.....	16
House Work.....	13
Course in Elementary Science.....	12
Combined University and Hospital Course.....	3

⁹ *Applications for Enrollment:*

1915 compared with 1920.

Schools showing increased number of applications.....	22
Schools showing decreased number of applications.....	24
Schools showing no change.....	0

¹⁰ *Age Limits for Entrance:*

Minimum of 17 years.....	3 cases
" " 18 ".....	38 "
" " 19 ".....	21 "
" " 20 ".....	25 "
" " 21 ".....	8 "
" " 23 ".....	1 "
Maximum of 25 years or under.....	3 cases
" " 26 to 30 years.....	29 cases
" " 31 to 34 ".....	17 "
" " 35 years.....	45 "

¹¹ *Causes for which Applicants to Training Schools were Rejected:*

Educational.....	133 instances
Age.....	85 "
Health.....	75 "

¹² *Supply of Textbooks and Uniforms:*

Replies received.....	94 Schools
Uniforms free.....	47 " 50%
Material free.....	8 " 9%
Text-books free.....	21 " 22%

¹³*Length of Annual Vacation:*

Three weeks.....	47
Two weeks.....	46
Four weeks.....	3

¹⁴*Shortage of Graduate Nurses:**1915 compared with 1920*

Replies received.....	72
Number of graduates in 1915.....	1,138
Number of graduates in 1920.....	1,519
Schools with increased output.....	46
Schools with decreased output.....	17
Schools with stationary output.....	9
Communities short of graduates.....	45
No shortage of graduates.....	46
Shortage for private duty.....	26
Shortage for institutions.....	8
General shortage.....	8
Shortage for midwifery.....	5
Shortage for infectious cases.....	2

Shortage attributed to:

Preference for public health or institutional work.....	11
Conditions in private homes.....	11
Emigration to U.S.A.....	6
Increased demand for graduates.....	5
Marriage.....	5

Question: "The following points have been advanced to explain the shortage of student nurses. From your general observation and without particular reference to your own school, what importance do you attach to each of these?"

<i>Answers:</i>	<i>Yes</i>	<i>No</i>
Other occupations are more attractive.....	53	20
The hours of duty are too long.....	50	26
The living conditions are uncomfortable.....	46	24
The lack of salary during training.....	39	31
The nursing profession is becoming commercialized....	40	18
After leaving High School I have to wait about 3 years until I am old enough to train.....	35	12
The food is poor or monotonous.....	37	31
There is too much menial work.....	34	36
I feel the lack of home and social connections.....	32	30
The vacation is inadequate.....	27	36
The educational standard for entrance is too high....	17	59
There are too many restrictions when off duty.....	10	54
Three years is too long to spend in training.....	7	79

The Canadian National Association of Trained Nurses

REPORT OF THE FORMATION OF A PUBLIC HEALTH SECTION

THE membership of the Canadian National Association of Trained Nurses, comprises practically all graduates of the recognized schools of nursing, who are practising in Canada. Building upon the traditions of the past and sometimes restricted by them, the leaders in the profession are attempting to meet new opportunities and to develop the many types of nurses required in Canada.

Preventive medicine is opening up new fields of service to the graduate nurse, as evidenced by the reports presented at this National Public Health Convention. When the nurse is employed by public and private organizations for the primary purpose of maintaining health rather than in the care of the sick, she becomes known as a Public Health Nurse, though the form of organization and the nature of her duties may vary.

The older and newer forms of service are frequently blended, making it a debatable question, whether she is or is not a Public Health Nurse. It is sometimes claimed that the title should be reserved for those employed by Departments of Public Health, but since health work is carried on by many philanthropic agencies and industries, independently, or in co-operation with public health departments, the Canadian National Association of Trained Nurses has decided to use the title in its functional, rather than in a departmental sense. In order more fully to develop the new type of nursing, the Canadian National Association of Trained Nurses has organized a public health section in which it is hoped all the members interested in public health work will be enrolled.

Each Province, with the exception of Prince Edward Island, which has not yet formed a Graduate Nurses Association, has elected a representative whose duty it will be to enroll public health nurses in their Section of that National Organization. Progress has already been made in every Province. The officers appointed are: Chairman, Miss Elizabeth Breeze, Supt. of School Nursing, Vancouver, B.C.; Vice-Chairman, Mrs. Charlotte Hannington, Supt. Victorian Order of Nurses for Canada, Ottawa; Secretary-Treasurer, Miss Muriel Mackay, Industrial Nurse, Hydro-Electric Power Commission of Ontario, Toronto.

With the co-operation of the Provincial branches of the Canadian Red Cross, the past year has brought amazing developments in Public

Health Nursing. The interest of the Universities has been aroused in the education of Public Health Nurses. Courses in public health nursing, with a total enrolment of 148 graduate nurses have already been begun in six Canadian Universities.

Vancouver—(a) 5 year course in Arts and Nursing (including Public Health). (b) 4 months course in Public Health Nursing.

Halifax (Dalhousie University)—6 months course, in Public Health Nursing.

Toronto—8 months course, in Public Health Nursing.

Montreal (McGill University)—(a) 8 months course in Teaching and Administration in hospitals. (b) 8 months course in Public Health Nursing.

London (Western University)—8 months course in Public Health Nursing.

Edmonton (University of Alberta)—3 months course in Public Health Nursing.

Leadership in the development of Public Health Nurses should come from the graduates of these University courses, who will identify themselves with every form of health service. It is not possible or necessary that all the public health nurses should have received post graduate training but the nursing profession looks to the graduates of these new departments to discover and develop the necessary types of workers.

The Public Health Section of the Canadian National Association of Trained Nurses will provide the nurses with an opportunity for assembling their experiences and to study the many new problems presented for solution.

The Canadian Nurse, the official magazine of the nursing profession will we hope record some at least of the achievements and failures of this newest branch of the profession. It is hoped that this new organization may have the co-operation of the National Public Health organizations since its object is to develop more efficient public health nurses for the work in which those organizations are interested.

The Victorian Order for Nurses

THE Victorian Order of Nurses for Canada held on June 8th, 1921, perhaps its most important annual meeting since its organization twenty-three years ago. Changes have been made on very broad and constructive lines, allowing for freedom of action as is in keeping with the forward movement of the Canadian Public Health policy.

This work can no longer be carried on by one agency, not even the governmental departments of the different provinces, but must be effected by the closest co-operation of all interested in the actual work. The Victorian Order of Nurses for Canada as a national Public Health Organization must above all others have "the forward looking vision". It was this habit of "seeing visions and dreaming dreams" that led a handful of women in Vancouver and Halifax to pass the inspiration to Lady Aberdeen in 1897, resulting in the birth of the Victorian Order of Nurses for Canada as rather an unwelcome child, with very little provision for its maintenance and the prospect of having "its own way to make in the world".

The Order has one great asset, twenty-three years experience in what was a pioneer field, and all this means in mistakes and valuable experience gained thereby. It would be well for many of the organizations entering the field to-day to profit by this garnered wisdom, instead of spending other precious years experimenting to gain what has already been proven.

On the other hand, the Order has "acquired merit" as Kipling says by eliminating from its policy methods of training and procedure which experience has taught are not progressive.

The annual meeting of the Board of Governors was called for June 8th and some months prior to that time the Chief Superintendent was instructed to summon to Ottawa the District Superintendents and such other executive nurses as could be spared from their posts to confer together and with the Executive Council so that some definite policy of progress could be presented to the Board of Governors.

This Conference of Nurses proved very fruitful in results. The question of public health nursing as a whole was considered, from the old district or bedside nursing,—the first form of public health nursing undertaken in Canada,—on through the twenty-three years of pioneer effort, broadening into the steadily advancing specialized form of nursing service as it is done to-day.

It was deemed necessary for the Victorian Order of Nurses to define Public Health nursing as understood by them and in harmony with the opinions of the best authorities of the Mother Country and the United States of America.

The aims and objects of the Order were drawn up at a time when Canada had no public health organizations, medical or nursing, to define its activities. It is a remarkable fact that the Honourable Mr. Justice Burbridge and Sir John Bernoit set so high a standard for the protection of the public, without professional advice, as that stated in our Royal Charter.

The nurses of the Order in conference requested that section 5 (a) of the Royal Charter:

The Objects of the Order are:

"To supply nurses, thoroughly trained in Hospital and District Nursing and subject to one central authority, for the nursing of the sick who are otherwise unable to obtain trained nursing in their own homes, both in town and country districts."

be changed to read:

The Objects of the Order are:

"To supply nurses, thoroughly trained in Hospital and Public Health nursing, and subject to one Central authority, for the nursing of the sick, the prevention of disease, and the promotion of health."

The substitution of the words "Public Health Nursing" for "district nursing" as the paragraph now reads will bring our work into conformity with the efforts of all agencies giving such service in Canada. The change in the latter part of the paragraph which reads, "for the nursing of the sick, the prevention of disease, and the promotion of health" will convey to the public consciousness the new hope that while we minister to-day as in former years to relieve the actual suffering of the sick at the bedside, we intend, by the wider application of our knowledge to ultimately mitigate disease and suffering. This is commonly expressed as "educational and preventive work".

During the past years many agencies have been trying to define the term "public health". In the altering of the term "district nursing" for the modern "public health nursing" it was deemed wise that the Victorian Order define this term, this definition to be embodied in the Royal Charter as follows:

"Public Health Nursing is a branch of Nursing service which includes all phases of work concerned with family and community welfare, with bedside nursing as a fundamental principle and developing from it all forms of educational and advisory administrative work that tends to prevent disease and raise the standard of the health of the community."

These amendments met with the approval of the Board of Governors and were accepted by them, evincing that in common with Mr. Justice Burbridge and Sir John Bernoit the Board intends keeping this service in the fore-front of progress so long as Canada shall have need of it.

The second important decision made at this Annual Meeting was in connection with postgraduate training in Public Health. As most Canadian Universities have established standard courses with a well balanced curriculum in academic and field work which meets with the approval of the Public Health authorities and the National Association of Trained Nurses it was decided that we provide scholarships for fifty graduate nurses to enter for the year 1921-22. These students being required to pledge themselves to one year's service with the Victorian Order upon completion of the Course. The Victorian Order of Nurses for Canada gives supervised field work in connection with these courses. This will standardize Public Health training all over Canada.

Another subject of importance was discussed, namely, the question of provincial organization. This will be very fully gone into in the autumn when the Executive Council intend making considerable changes in the methods of carrying on the work.

The executive nurses of the Order are preparing a *Manual of Routine* in order that the work may be conducted in a perfectly uniform manner. This has been done in the past and it was deemed wise to crystallize these methods into printed form for the future good of the nurses of the Order.

A council of nursing will be formed which will act in an advisory capacity to the Executive Council.

Dr. M. T. MacEacheran, President of the Vancouver Provincial Association gave the Executive Council one day of his time whilst in the East, which should result in the strengthening and advancement of the work of the Victorian Order of Nurses for Canada.

Social Background

NEIGHBOURHOOD WORKERS ASSOCIATION REPORT FOR YEAR 1920-1921

New cases for which full responsibility was assumed.....	133
Cases accepted for consultation only.....	253
Total.....	386

Two thousand years ago a woman was stoned to death in public for committing the unpardonable sin—the breaking of the seventh commandment. To-day in any of the old churches in Scotland a visitor can see for sixpence the “Penitents’ Bench” and other instruments of torture used within the last few centuries to punish the same offenders. Within more recent years the matter has been left severely alone, never being mentioned in public or even thought of in private by people who considered themselves respectable. And all this time the illegitimate birth rate has steadily increased as none of these methods have led to an intelligent understanding of the problem. We do not claim now that we have discovered any infallible remedy for the evil but we do feel that we are travelling in the right direction when we devote our best efforts to a careful and serious consideration of the underlying causes so that effective, preventive and remedial measures can be taken. There is just one way in which this can be gained—through a personal intimate knowledge of the only people on earth who know anything about the subject—the parents, who have arrived at this holiest of human experiences by such an unhallowed road. For this purpose the Department for Unmarried Mothers was created.

The work in this Department is carried on in very close co-operation with other social agencies in the city. When illegitimate births are reported to the Public Health Department the nurses in the districts and hospitals refer the cases to this office and the responsibility in the matter is divided between the nurses and our workers, according to the nature and needs of the patients. The agency which seems best equipped and adapted to cope with any particular problem assumes full responsibility, the other acting in a consulting capacity. The same co-operation exists with the institutions when such care is necessary for a mother and baby during the nursing period, but unless it is considered a permanent institutional case, the caseworker makes the ultimate plans for them

and undertakes the future supervision. But with the great number of problems of this sort needing adjustment and the formidable difficulties usually involved, it requires constant consultation and all our combined efforts taxed to their utmost capacity to make any headway at all. Even then we often feel that we are not coping with the situation but merely scratching the surface.

The girls coming to us vary in type from the low grade mental defective to the intelligent well educated stenographer or teacher. Between these extremes are the domestic, factory worker, waitress, telephone operator, sales girl, dressmaker and girls in every occupation and our policy must be sufficiently elastic to include them all.

It almost invariably happens that the finer girl of every type wishes to keep her baby although it is almost a superhuman undertaking, but that effort seems to be the making of her. It is these girls who need their income supplemented and our constant support and encouragement.

Sometimes it seems necessary to separate mother and child but these mothers constitute the most difficult cases for supervision for it is the girls whose babies have died or been adopted who comes to us for help in their second pregnancy.

For the last year, we have been carefully following the career of a young girl who very obviously needed her baby. As long as she was kept in close touch with the child, she was a good mother and her conduct has been all that could be desired. But whenever she has been relieved of that responsibility there have been unmistakable symptoms of a moral collapse. Consequently we have felt justified in persistently discouraging her frequent desire of adopting the child and have forced the burden on her, at the same time making it possible for her to bear it financially and otherwise. It has been a long hard struggle but we felt it was worth while as the girl's ultimate welfare and happiness were at stake and so it has turned out. She has since married, but with a physical disability which prevents her from again experiencing the joy of motherhood and this baby, once an outcast, has become the most precious and indispensable member of the little family.

Recently one of our workers was called over the long distance telephone by a young mother who had previously showed the greatest courage and patience under the most trying circumstances. She wished to report a very satisfactory and happy solution of her problem, and to express her appreciation of all that had been done for her by the Association. Our worker reminded her that positively nothing had been done for her and that if her troubles were over the credit was entirely due to herself. "But you do not know", she said, "what a help it was to feel that I could go to you at any time and talk things over as a friend without being made to feel like the most hopeless sinner on earth".

Sometimes we can best serve these girls by providing for them financial help or legal or medical advice. Sometimes by securing a position for the mother and a boarding home for her baby. Often we can act as a medium between her and the child's father, protect her from public humiliation or effect a reconciliation between her and her relatives. But more than anything else they seem to need a friend who will help them up when so many forces are tending to push them down, someone who has faith in them and will develop their faith in themselves, that they "May rise on stepping stones of their dead selves to higher things".

The new Act passed by the Ontario Legislature "For the Protection of Children born out of Wedlock" whilst not all that could be desired, should go a long way toward a more equal division of responsibility. The penalty for a wrong committed by two people has heretofore been paid only by one and usually involves, with cruel injustice, the third and un-offending party—the innocent child. We anticipate with careful administration of the Act, a very material decrease in the illegitimate birth rate in Ontario.



The Provincial Board of Health of Ontario

COMMUNICABLE DISEASES REPORTED BY LOCAL BOARDS OF HEALTH FOR THE MONTH OF APRIL, 1921.

Diseases	1921. April.		1920. April.	
	Cases	Deaths	Cases	Deaths
Small-pox.....	383	2	305	4
Scarlet Fever.....	365	7	487	12
Diphtheria.....	409	34	418	58
Measles.....	284	0	1618	27
Whooping Cough.....	165	16	135	17
Typhoid.....	32	5	33	14
Tuberculosis.....	196	121	223	193
Infantile Paralysis.....
Cerebro-Spinal Meningitis.....	7	6	7	5
Influenza and Pneumonia.....	90	30	177	143
Primary Pneumonia.....	...	250	...	302
	<hr/> 1,931	<hr/> 471	<hr/> 3,403	<hr/> 775

VENEREAL DISEASES REPORTED BY MEDICAL OFFICERS OF HEALTH.

	April. 1921.	April. 1920.
Syphilis.....	219	93
Gonorrhoea.....	236	137
Chancroid.....	1	7
	<hr/> 456	<hr/> 237

SMALL-POX CASES REPORTED BY LOCAL BOARDS OF HEALTH FOR THE MONTH OF APRIL, 1921

County	Municipality	Cases	Dths.	County	Municipality	Cases	Dths.
Brant—Brantford.....		11	1	Parry Sound—Parry Sound		5	0
Burford.....		2	0	Hagerman....		16	0
Carleton—Ottawa.....		116	0	McKeller....		1	0
Nepean.....		14	0	Perth—Stratford.....		1	0
March.....		4	0	St. Marys....		3	0
Fitzroy.....		1	0	Elma.....		4	0
Elgin—St. Thomas.....		11	0	Prescott & Russell—N.			
Essex—Essex Border.....		3	0	Plantagenet.....		4	0
Frontenac—Kingston.....		4	0	Prince Edward—S. Marys-			
Kingston Tp...		4	0	burg.....		1	0
Grey—Collingwood Tp...		9	0	Hillier.....		1	0
Sullivan.....		1	0	Renfrew—Raglan.....		14	0
Hanover.....		5	0	Bagot.....		8	0
Halton—Burlington.....		1	0	Rainy River—Emo.....		4	0
Hastings—Belleville.....		4	0	Dilke.....		4	0
Deseronto.....		2	0	Lavallee....		2	0
Huron—Blythe.....		1	0	Simcoe—Beeton.....		1	0
Kent—Chatham.....		3	0	Alliston.....		2	0
Zone—Zone.....		1	0	Adjala.....		3	0
Kenora—Kenora.....		2	0	Oro.....		1	0
Lambton—Brooke.....		1	0	Orillia.....		1	0
Moore.....		1	0	Stormont D. & Glengarry—			
Lanark—Lanark.....		4	0	Iroquois.....		2	0
Perth.....		2	0	Sudbury—Sudbury.....		6	0
Beckwith.....		5	0	Waters.....		2	0
Ramsay.....		1	0	Copper Cliffe..		2	0
Darling.....		1	0	Temiskaming—Haileybury		3	0
Leeds & Grenville—Brock-				Waterloo—Kitchener....		6	0
ville..		1	0	Wellington—Arthur Village		1	0
Lennox & Addington—				Eramosa.....		5	0
Ernesttown.....		1	0	Wentworth—Hamilton...		12	0
Middlesex—London.....		4	0	Barton.....		3	0
Muskoka—Morrison.....		3	0	Waterdown...		2	0
Nipissing—Ferris.....		1	0	Dundas.....		4	0
Norfolk—Walsingham N..		2	0	York—Toronto.....		10	0
Northd. & Durham—Bow-				Newmarket.....		7	0
manville.....		7	1			—	—
Ontario—Rama.....		1	0			383	2
Oxford—Woodstock.....		4	0				

News Items

Mrs. Emmeline Pankhurst speaking for the Canadian National Council for Combating Venereal Diseases during the month of May addressed large meetings on the subject of "Social Hygiene" in the following cities: Toronto, Windsor, Winnipeg, Portage la Prairie, Brandon, Regina, Calgary, Edmonton, Lethbridge, Medicine Hat, Vancouver and Victoria. Reports from all of these cities indicate that Mrs. Pankhurst's earnest message left a deep impression and that her tour has done much to further the interests of the Council.

Dr. Franklin B. Royer of the Massachusetts-Halifax Health Commission was a forceful and useful speaker in various parts of New Brunswick during the recent successful Health Week.

The Canadian National Association of Trained Nurses has organized a Public Health Section.

The Ontario Medical Association under the Presidency of Dr. J. Heurner Mullin held its Annual Meeting during the first week in June at Niagara Falls. An especially interesting feature of the meeting was the Round Table Dinner which provided an opportunity for the discussion of many problems in which both the medical profession and the public are greatly interested. This unique departure was one of numerous interesting developments which have resulted from the initiative and energy of the retiring president.

Miss Jean E. Browne has returned to Canada after a year's study of public health nursing in England and France, where she held the Canadian Red Cross Scholarship in the International Public Health Nursing Course held under the auspices of the League of Red Cross Societies. She will resume her duties as Director of School Hygiene in the Province of Saskatchewan.

The first film produced by the Pathescope Company of Canada under the direction of the Child Hygiene Section of the Canadian Public Health Association is now available.

It is a two reel film, lasting about thirty-five minutes, and endeavours to teach the proper care of the infant. Mrs. Emory, a middle class mother, who had registered the birth of her baby, Betty, thereby securing

literature from the Health Authorities and advice from the Public Health Nurse, is shown in contrast to Mrs. Doyle, a poor mother, who did not register Baby Jack's birth, and who is found by the nurse, when her baby is the pitiful victim of ignorance, improper feeding, and all the other enemies of infancy.

Among the lessons taught in this delightfully interesting story, are: The proper method of bathing a baby; how to dress a baby; feeding—good and bad; the use of a mask; baby's bed and sleep—indoors and out; and the operation of a Child Welfare Clinic.

For further indormation, write—Child Hygiene Section, C.P.H.A., 206 Bloor St. W., Toronto.

Miss Laura Holland has taken up her duties as Director of the Nursing and Emergency Department of the Ontario Division of the Canadian Red Cross Society. Miss Holland, who is a graduate of the Montreal General Hospital, served Overseas with the Canadian Army Medical Corps and on returning, took the Social Service course at the Boston School for Social work. During the past year she has been Social Service worker at the V.D. Clinic of the Montreal General Hospital.

On Monday, May 31st, a meeting of representatives of organizations interested in Child Welfare, was held in Ottawa, under the auspices of the Deputy Minister of Health, for the purpose of electing the officers of the Canadian Conference of Child Welfare and discussing a programme for the coming year.

Mrs. Wm. Todd, who was appointed chairman of the Provisional Executive at the meeting held last October, occupied the chair, and the following officers were elected: President, Mr. J. Arthur McBride, Montreal, P.Q.; 1st Vice-President, Mrs. Wm. Todd, Orillia, Ont.; 2nd Vice-President, Miss Elizabeth Breeze, Vancouver, B.C.; Secretary, Miss Charlotte Whitton, Toronto, Ont.; Treasurer, Mme. Jules Tessier, Quebec, P.Q.

The Child Hygiene Section of the Canadian Public Health Association have now ready for distribution their miniature school posters.

These are reproduced in colour about post card size and weight, each poster having on the reverse side, a health talk on the subject illustrated.

One set comprises twelve posters, teaching health habits to children, by telling the story of an average day, in the life of a school girl and boy.

Sale price, 5c. a set—express collect. Address 206 Bloor St. W., Toronto.

Editorial

A BETTER PROGRAMME

IT would appear that the evolution of the most modern programme for the prevention of disease must necessarily mean a broadening of all of our conceptions of preventive medicine. It seems so short a time since the leech and the barber surgeon held sway. Only yesterday Simpson and Morton discovered their precious gifts for suffering humanity and in the time of most of us Pasteur and Lister opened for the wondering eyes of the world their astounding new chapter in the history of medicine. But the end is not yet.

The multitudes still toil on and suffer. Hospitals multiply, clinics abound that those who have found the pursuit of happiness little more than a fight for life may be cared for, Tuberculosis, ordinary infectious diseases, multitudinous accidents, typhoid fever, industrial diseases, the venereal diseases, they and their kind serve as eternal reminders to us not only that the sick and wounded must be cared for but that somewhere our machinery of prevention is falling down.

Dr. Saleeby's statement at the recent meeting of the Canadian Public Health Association that the campaign against venereal diseases in Great Britain has signally failed was, one is prone to believe, based on statistics as to the increased attendance at venereal disease clinics. Such attendance might easily be a sign rather of success than of failure. The implied suggestion was that fundamental factors, notably alcohol, had been neglected and certainly where the social and moral factors in disease production are forgotten we need not hope for ultimate success, either in the fight against venereal disease or disease generally. Economic conditions, religion, education, housing, recreation, the age of marriage, the quality of food all play their part and must all be considered. Health authorities are beginning to think of these things, but there's a long road yet to travel.

Book Reviews

Pulmonary Tuberculosis. By Edward O. Otis, A.B., M.D. Boston, W. M. Leonard, 1920. Canadian Medical Association, Montreal. Cloth, pp. 212.

The first edition of this excellent text-book appeared in 1917 under the modest subtitle, a text-book for students. Its title page now carries the more appropriate legend, a text-book for students and practitioners.

In addition to a careful revision, much valuable matter has been added including "The examination of soldiers for tuberculosis", as laid down by Colonel Bushnell, head of the Department of Tuberculosis in the U.S. War Office. There is also included the scheme of Major Stoll on the Essential Points in Physical Diagnosis. We are pleased to see also the "Diagnostic Standards" of the National Tuberculosis Association which form an admirable presentation of the subject.

Numerous well written case histories illustrate various points the author wishes to emphasize. His therapeutics are sane and safe and represent the opinions of a physician who has had a long and varied experience in tuberculosis as well as in general medicine.

Among other subjects, climate, after cure and marriage receive appropriate treatment.

We can highly recommend the work as a most excellent manual on the subject of pulmonary tuberculosis, and though written for the physician and student in medicine will give much information to the social worker, but it is especially for the busy general practitioner and the student that it forms a convenient and concise ready reference manual.

J. H. ELLIOTT.

Practical Tuberculosis. By Herbert F. Gammons, M.D., St. Louis; C. V. Mosby Co., 1921. McAinsh & Co., Toronto. Cloth, Pp. 158. \$2.00.

This small book is probably well conceived but so badly executed as to warrant its withdrawal by the publishers. Murdered English, misleading half truths, and careless statements abound throughout it, and quite spoil a book which contains much of merit. Some sentences which could be multiplied beyond the space available to the reviewer, are here presented: "He (the examiner) must be able to hear and have a stethoscope that is comfortable to the ears *and* auditory canal." "It is very evident that a physician would have a very poor practice who did not have at least twenty tuberculosis patients under his supervision each year." "In nearly all adults one will find fine crackles in the lower

axillary region on deep inspiration; naturally one should be suspicious of tuberculosis in these cases." "The diseased voice transmission is very variable." "Exaggerated resonance is usually an indication of emphysema." "Neuritis is a frequent complication of tuberculosis even in the early stages, and we must consider the possibility of all neuritis attacks as resulting from tuberculous infection." "Blow-ups in tuberculosis are considered due to *extension of the bacilli* through the lymphatics." "Inspiration is voluntary, while expiration is due to the elasticity of the lung tissue and also to the contraction of the chest muscles and diaphragm." "In the healthy adult male about 20 c.c. of air are introduced into the lungs and bronchial tubes during each inspiration." "Tuberculosis patients often lower their temperature by exercise." "Coughing usually results from an irritation in the laryngeal passages." "Vaccination has often lit up tuberculous infections." "Do not forget that Nature has cured many tuberculous persons, and that medicines, vaccines and serums have killed more patients than they have cured." "Resorting to the use of opiates should be delayed as long as possible, *because frequently opiates prolong the life* of these hopeless incurable cases, who have an impaired mind which causes them and their associates much discomfort."

He states that artificial pneumothorax should be given by a specialist, yet goes on to describe the operation in such a manner that if any attempt were made according to his directions, disaster would almost surely follow.

After making a good statement of the value and limitations of the X-ray in diagnosis and pointing out that only good plates are of value, he uses for illustration some four plates whose lack of detail make them as valueless as those he decries.

The names of men prominent in the history of medicine and tuberculosis are frequently mis-spelled and the legends under the illustrations show great carelessness in writing and typography.

There is no excuse for the appearance of a book full of such glaring defects and mistakes.

J. H. ELLIOTT.

Notes on Current Literature

From the Department of Information on Public Health, Canadian Red Cross Society

INTERESTING ARTICLES IN RECENT PERIODICALS

What is a Health Centre?

"The Nation's Health", May 1921. Page 265.

Dr. Peterson, National Director of Health Service of the American Red Cross, writes a timely article that should help to mould opinion regarding the organization and function of health centres, which he summarizes as follows: "The health centre is a community health organization standing for creative work, which aims to co-ordinate the efforts of all health agencies, bring the services of all agencies to the attention of the public in such a way that they are used, bring the community to demand, and stimulate the community to work for a higher and higher type of health service".

Health Problems of Women in Industry.

"The Nation's Health", May 1921. Page 304.

Health in Industry and Efficient Production.

"National Health", May 1921. Page 312.

The Relation of Posture to Individual Health.

"The Nation's Health", May 1921. Page 290.

What the Air Does to Us.

"The Nation's Health", May 1921. Page 265.

The effects of the temperature, humidity and movement of air upon the efficiency and health of indoor workers.

Health Education in Industry.

"American Journal of Public Health", June 1921. Page 489.

The Education of Health Officers.

"International Journal of Public Health", May-June, 1921. Page 263.

A review of the general and special educational standards for health officers and an outline of University courses in Great Britain, Canada and the United States.

The Nucleus of the Tuberculosis Problem.

"International Journal of Public Health", May-June, 1921. Page 225.

The Director of the American Red Cross Tuberculosis Commission considers that the customary forms of propaganda against tuberculosis result only in the waste of time, energy and paper. In his opinion, the

real nucleus of the problem lies in new knowledge gained by scientific research and in the instruction of school children by trained teachers.

The Anti-venereal Campaign.

"International Journal of Public Health", May-June, 1921. Page 257.

Professor Gougerot of Paris, summarizes the methods of anti-venereal propaganda in vogue in France. Special emphasis is attached to the importance of courses of instruction in social hygiene.

The Pregnant Woman in Industry.

"Journal of Industrial Hygiene", June 1921. Page 39.

The Prevention of Venereal Infection.

"The Journal of State Medicine", May 1921.

An excellent symposium discussing this controversial question from three different points of view. Dr. Lyster, of St. Bartholomew's Hospital, London, presents a clear and forceful plea for prophylaxis as an effective means of control. Dr. Bayet, of Brussels, maintains that the present system of prophylaxis is a complete failure, and argues that the most effective means of prevention is the treatment of existing cases. Dr. Lomholt, of Copenhagen, describes the experience of Denmark.

Venereal Disease Clinics.

"International Journal of Public Health", May-June, 1921. Page 295.

Lieut.-Col. T. F. Ritchie, of the Division for Combating Venereal Diseases, League of Red Cross Societies, discusses the organization and function of these clinics under the following headings:

1. Situation of Venereal Disease Clinics.
2. General Arrangement of the Clinic.
3. Treatment Rooms.
4. Records.
5. Follow-up work.
6. Personnel.
7. Financial Arrangements.

Illitimacy in a Rural Community.

"The Survey", June 4th, 1921. Page 305.

How Child Welfare Work Can Be Assisted in the Rural Districts of British Columbia

BY MISS JESSIE FORSHAW,

ORGANIZER,

Victorian Order of Nurses in British Columbia.

Read at the Annual Meeting of the British Columbia Child Welfare
Association.

MY travels through British Columbia have not taken me to every little community; nevertheless, I think that I have seen sufficient of rural life to recognize a few of the disadvantages with which the country child is surrounded. True, there are advantages to be gained from life in the open country, so many in fact that are conducive to developing good Canadians, that we should aim to make rural life as attractive as possible, and give to the rural child a few of the advantages which the city child receives.

In considering the rural problems and disadvantages which affect child welfare, it will be necessary to make a classification of its phases. Upon analysis, we find that the general development of the child is dependent upon his physical condition, spiritual and social welfare, and mental development. They are so closely allied that the extent of their respective development depends a great deal upon each other. In considering the child's physical welfare we must recognize that primarily it depends to a considerable extent upon heredity and environment. His mental development depends almost entirely upon the same factors. His social and moral welfare more upon environment.

To deal first with the child's physical well-being, we cannot dodge the fact that the rural communities lack a proper system of public health and school nursing, and I think it is agreed upon that every child should be given an equal chance for health, and children in the rural districts should have the advantages which accrue from school nursing as well as those in the city. The installation of public health nurses is left to the initiation of each local community, which can only result in a haphazard system. We all realize that before there can be successful and systematic

application of any new movement, there must of necessity be educated public opinion behind it, and, to demonstrate any new movement to educate the public, present conditions force a haphazard system of demonstration. However, the health of each community and the lowering of mortality rates, especially infant mortality, should be, and in some countries is a matter of national importance and is considered a state function, not to be left to the pleasure of communities and voluntary organizations.

In dwelling upon this phase of child welfare I wish it to be borne in mind that there are authoritative bodies both governmental and voluntary, whose function is to deal with this matter, and who are carrying on their work successfully as far as lies within their present power, and in mentioning this existent need I do not wish to be misunderstood. The success of any service lies in the allocation of work to the proper authorities, by co-operating, but not over-lapping, the recognition of limitations whether it be organizations or individuals, and the willingness to delegate to others work which can be better done by them.

I cannot pass over physical welfare without mentioning the trouble caused by lack of dental facilities. If some system could be evolved whereby travelling dental clinics, pay and otherwise, could be provided for the rural districts, a great amount of good could be accomplished. It is of little use to preach oral hygiene if there are no provisions made whereby such teaching can be carried out.

Now, to turn to the problem of social and moral welfare. If they depend greatly upon environment we shall have to first analyze contributing factors that make up the environment. The most important are: the home, the school, the child's associates, church or Sunday school, the social life and morale of the community, local industries, resources and wealth, type of recreation and amusement provided for the children. If any of the above factors are at fault, it will usually result in an environment detrimental to the child. The unconscious blending of the surroundings which constitute the child's environment can be made advantageous. In order to get the most healthy environment there should be a particular agency, organization or influence to deal with and build up each factor.

The home may be greatly influenced by the community atmosphere. On the other hand, there may be sufficient wisdom and strength, or indifference, in the home to offset any influence for good or evil which the community may have.

I will not go into detail as to the part each agency can play in moulding the child's environment, but may I pause long enough to mention two agencies, who, in the discharge of their respective duties, can extend them in such a way as to help the home environment. They are the school teacher and the public health nurse. The school teacher can teach subjects to her pupil which go toward making good citizens. Such teaching will be unconsciously introduced to the home by the child himself, and the child becomes the teacher of the parent; and both are unconscious of the fact. The public health nurse has the privilege of entering the home, and through that privilege and many other opportunities she may tactfully help to adjust a faulty home environment.

Unless there is an interest taken in the child's environment as a whole, there will not be the success there should be, hence the need for better co-operation among the various agencies engaged in child welfare, and a point of centralization created providing the means whereby co-operation can be engaged in with some organized system before we can expect co-operation. We must get some system so that we will know how to co-operate.

While we are still on the subject of social welfare I wish to impress a most important need—more organized recreation and play.

One of the greatest drawbacks to living and bringing a family up in the rural districts is the lack of proper facilities for education and recreation, which are possible in an urban population, and which it demands. Life is more isolated in the country, naturally, than in congested centres, or even small towns, with the result that children are not trained for the competition which they meet with in the city. The rebound from an early environment in the country to the conditions of the city is apt to bring in its train unhappy and painful results. Every child should be trained in the principles of clean, healthy play and amusement, so that when he is called upon to make the decisions which life in a city force, he will not be handicapped by lack of clean, honorable principles. When we pass over the possibilities of play we are overlooking a great educational factor. There is a great tendency to overlook play and recreation in the rural districts for the very obvious reason that there are not at present the proper facilities for conducting proper play and recreation, nor does there seem to be sufficient public awakening to the great educational value of play.

Much could be done to correct this condition, but it needs some

organization to take charge of this work and aim to put rural social life on a better basis, especially for the children.

The Playground and Recreation Association of America takes charge of this division of work in the United States. With this association are affiliated various other organizations whose aim is to improve community life, both urban and rural. Its aim is to supply information, assistance regarding the organization of clubs, playgrounds, forms of recreation, and to supply instructors, playground supervisors, etc. I was anxious to start some club work in a rural district for the school children and those of 'teen age, to whom I could write for information and ideas, as I wanted to pick out some form of organization which would suit the community. Perhaps it was due to my ignorance, but I did not know of any organization in British Columbia, or in Canada for that matter, which could supply me with the information I needed. My difficulty only represents the difficulties of others should they be anxious to organize some form of community recreation and children's clubs.

I would like to take this opportunity to suggest that a Bureau of Recreation and Playgrounds for urban and rural districts be created, if there is not already such a bureau in existence. I think that this bureau could quite well form a department of the Provincial Child Welfare Association, and be under its direct supervision. The concrete result which I would like to see accrue from this paper is the creation or more active development of such a bureau, and I hope it will form the nucleus of discussion in connection with this paper, provided it is worthy of one.

Before leaving the problem of organized and supervised play for the rural districts, I must point out that it would be impractical and too expensive to engage salaried play leaders. The only way in which to get around the problem as far as I can see is to get the closer co-operation of the school teachers. I think that some teachers are supervising or leading their playgrounds already, but it is only sporadic. There should be some organized system for dealing with this. The Federation of School Teachers for British Columbia would, I am sure, give any such movement their heartiest co-operation if they were approached from this association. In addition, may I suggest that the Teachers' Summer School might include more lectures dealing with child psychology and the social life of the child, and how to develop good playgrounds, recreation centres, etc.

But please do not shift the recreation problem to the School Teachers' Association entirely.

Without a department or bureau to handle the question of playgrounds and recreation the teachers will only have to do as I have done—apply to American organizations, and with all due respect to the United States, is there anything to prevent Canadians attempting at least to solve their own problems? I trust that I have made my object clear. The need of a central bureau to deal with playgrounds and recreation for urban and rural centres throughout British Columbia.

With that object firmly fixed in mind, let us turn from the social and moral welfare of the child to his mental and intellectual development. I must, however, first apologize for encroaching upon a science which I have not been educated or trained for, but in my association with rural schools the fact that there are so many feeble-minded children in our public schools has been so painfully demonstrated to me, that I cannot pass by without saying something in regard to the matter. I can only hope, in so doing, that those who are an authority on the subject of mental and nervous conditions will better explain that which I have clumsily but sincerely tried to say. I can truthfully say that I have never yet visited a rural school but what I have found one or more feeble-minded children there, and in the last analysis, when our problems of social welfare have all been sifted and weighed our greatest stumbling block to social progress is the high grade moral and mental deficiency of various kinds and the social problems caused by and through them. Until that problem can be solved we are pouring all our efforts along social welfare into a leaking barrel. True we cannot initiate any drastic measures to remedy this condition; we must first have the backing of public opinion which can be secured only through education. But I think much more could be done.

I do not think that I am altogether Utopian when I picture travelling psychologists or mental specialists who will visit the rural schools upon the same basis as the medical school inspector and school nurse for the purpose of finding the mentally defective or any symptoms of mental disease, as does the medical man for physical defects. A chain of psychiatric clinics attached to the larger hospitals throughout the province, which can be used for the observation and diagnosis of mental cases, with special schools provided for the feeble-minded and a follow-up system of mental hygiene nursing.

Sometimes I think that people tire of hearing the problems of the rural districts sounded, but the fact remains that if we are to have a healthier, better race, and if the country is the ideal place for the nursery of the nation, we must remove some of its big disadvantages, or the nursery will not be giving to the nation the kind of men and women we need.

With determination, time, patience and a few other virtues we can and will succeed, not for ourselves alone, but for the future of our sons and daughters—for Canada—and our Empire.
